

**Consent for Release of Information
Department of Human Services
Maryland Long-term Care Medical Assistance Program**

I, Print Customer's name here hereby authorize the Department of Human Services to verify my income, including but not limited to, Social Security, Supplemental Security Income, Veterans Benefits, private pensions, Long-Term Care Insurance, disability insurance, earned income, etc.; my resources, including but not limited to, checking and savings accounts, certificates of deposit, individual retirement accounts, stocks, bonds, etc.; real property and any other personal property of value; mortgage information on real property; life insurance face and cash value; expenses to determine appropriate allowances; and, any other documentation relevant to my eligibility for participation in programs administered by the Department of Human Services.

I also authorize any person, partnership, corporation, association, or governmental agency possessing information on such matters to release such information to the Department of Human Services. I certify that I have read the above statement and understand that this gives my permission for release of such information.

Name of Institution

Address of Institution

Account Number

To be completed by Applicant/ Authorized Representative

Applicant's Social Security Number

Date of Birth

PRINTED Name of Applicant or Authorized Representative

Signature of Applicant or Authorized Representative

To be completed by Spouse

Social Security Number

Date of Birth

Spouse's Signature